CONTENTS

CHAPTER 4. SERVICES OPERATIONS

PARAGRAPH PAGE

4.01 Client Folders and Clinical Records 4-1

4.02 Intake and Psychological Assessment 4-1

4.03 Counseling Plans 4-3

4.04 Supporting VA Medical Facility 4-4

4.05 Case Management 4-4

4.06 Case Conferences and Supervision 4-4

4.07 Clinical Coordination and Professional Collaboration
Between Vet Centers and VA Medical Centers 4-5

CHAPTER 4. SERVICES OPERATIONS

4.01 CLIENT FOLDERS AND CLINICAL RECORDS

a. Nonpsychological Counseling Record Content. Readjustment counseling includes nonpsychological readjustment counseling services to veterans (see M-1, pt. II, ch. 3, par. 3.03). In those cases, only veterans demographic intake information should be completed, and a "SOAP" notation (see NOTE) should be made about the purpose and outcome of the visit. If later the veteran is provided with psychological counseling services, a complete counseling intake/assessment should be completed. It is recommended, if the veteran is willing, that if the demographic data indicates Vietnam or post-Vietnam combat service, a counseling intake/assessment be completed in order to determine if psychological counseling services are appropriate.

NOTE: The definition of "SOAP": S = what the client Says, O = what the clinician Observes; A = clinician's Assessment; and P = Plan or Prognosis. (See counseling plan format in par. 4. 03b.)

b. Counseling Record Content. Every counseling record should contain as distinct, separate, and easily identifiable, each of the following sections:

(1) Veteran demographic intake information.

(2) Counseling intake/assessment.

(3) Content/format for individual case notes.

(4) Content on case closing summaries.

(5) Group counseling documentation.

(6) VA Form 10-1415, Medical Record Problem List.

c. Significant Others. Significant others are seen if necessary to provide adequate readjustment counseling services to the veteran. Client numbers and records are maintained in the name of the veteran; however, counseling case notes/progress notes on visits by significant others should be maintained as discrete and separate from the veteran's notes for continuity of notation, and so they can be easily extracted if a request for the veteran's counseling record is made.

4.02 INTAKE AND PSYCHOLOGICAL ASSESSMENT

a. Counseling Intake. The following information should be completed no later than the close of the third counseling session, when practical and feasible, or as soon as possible thereafter:

(1) Date.

(2) Name.

M-12, Part II April 21, 1992
Chapter 5

(3) Client number.

(4) Address.

(5) Home/work telephone numbers.

M-12, Part II
Chapter 5 April 21, 1992

(6) Date of birth.

(7) Gender.

(8) Ethnicity.

(9) Significant other/partner/next of kin.

(10) Martial status.

(11) Education.

(12) Employment status.

(13) Type of employment.

(14) Dates of service.

(15) Branch of service.

(16) Number of months in the Republic of Viet Nam, or other theater of combat operations.

(17) Combat/noncombat.

(18) Wounded.

(19) POW (Prisoner of War).

(20) Type of discharge.

(21) Service connected disability.

(22) Currently/recently seen at VA (Department of Veterans Affairs) facility.

(23) Counselor assigned.

b. Psychological Assessment

(1) Title 38 U.S.C. (United States Code) 1712A, requires that a general psychological assessment be conducted on each eligible veteran receiving counseling. It is important to note that some Vet Center clients receive information, technical assistance, or referrals that do not involve psychological counseling. When there is evidence of possible psychosocial problems or symptoms that may require a counseling or psychotherapy intervention, the general psychological assessment should be conducted.

(2) As much as is relevant of the following information should be completed for psychological assessment:

M-12, Part II April 21, 1992
Chapter 5

(a) Presenting Problem/History of Presenting Problem. Frequency, duration, severity, history of psychotherapeutic treatment, services sought at center.

(b) Present Social/Familiar Context. Family composition, type of employment, life style, alcohol/drug use, friends, support systems, medical problems, current

M-12, Part II
Chapter 5 April 21, 1992

psychological/medical treatment, typical day, pleasure/recreation, client's therapeutic goals.

(c) Pre-military History. Family of origin, school involvement, substance abuse, acting out/legal problems, trauma (death in family, incest, abuse, disasters, etc.).

(d) Military History. (Pre/during/post deployment). Adjustment, draft/volunteer, disciplinary actions, duties, injuries, disabilities, trauma, homecoming.

(e) Post/Military History. Social/interpersonal functioning, schools, jobs, marriages, children, etc.

(f) Observations. Appearance, behavior, speech, effect, mood.

(g) Assessment. Assessment of veteran and presenting problem(s). Discussion of the veteran's strengths, assets, motivation, support systems, and counselor's conceptualization and impression of the veteran. The relationship of the presenting problems to military history.

(h) Critical Issues. For example, assessment of suicidal/homicidal ideation, history of, and need for intervention.

(i) Plan. Specific actions/steps to be pursued by counselor, referral, consultation, length of treatment anticipated.

(j) Completion

1. Counselor's signature and date.

2. Signature of reviewing person (Team Leader/Clinical Coordinator), and date reviewed.

4.03 COUNSELING PLANS

a. Counseling Plan Content. All counseling plans will contain the following:

(1) Specific actions/steps to be pursued by counselor.

(2) Referral.

(3) Consultation.

(4) Type of counseling or therapy.

(5) Duration of counseling or therapy anticipated.

(6) Counselor's signature and date.

b. Counseling Plan Format ("SOAP")

M-12, Part II April 21, 1992
Chapter 5

(1) S - Presenting problem as reported by veteran, description of veteran's current situation, services being sought.

(2) O - Counselor's observations of the veteran, appearance, affect, mental status, actions, general presentation.

M-12, Part II April 21, 1992
Chapter 5

(3) A - Counselor's assessment, conceptualization of presenting problem.

(4) P - Counseling/Action plan based on assessment.

4.04 OUTREACH, COUNSELING, NETWORKING, REFERRAL, FOLLOW-UP, AND CLOSINGS

a. Outreach. Outreach comprises activities which result in identifying, locating, contacting and engaging eligible clients. Due to the importance of outreach for the RCS mission, each Vet Center is required to maintain a written outreach plan specific to the needs of the catchment area served.

b. Counseling. Vet Center staff offer a range of counseling services to include individual, group, marital and family counseling. Staff with appropriate training (psychiatrists, social workers, psychiatric nurse clinical specialists and psychologists) provide psychotherapy as indicated.

c. Networking. Networking is a process of developing beneficial interagency relationships with VA and non-VA service providers to include community service facilities, media, service organizations, and other government institutions.

d. Referral. The making of appropriate referrals is essential to the quality and effectiveness of the services delivered to clients. It is necessary when it is determined that the severity or nature of the client's presenting problems are beyond the scope of the team services or expertise.

e. Follow-up. Follow-up is accomplished by the regular use of suspense files with written and/or telephone contact.

f. Case Closings. Each Vet Center maintains regular routines for file review and closings of inactive cases, to be accomplished within 90 days of final visit.

4.05 CASE MANAGEMENT

a. Clinical Folder Review. Counseling folders should be reviewed following completion of intake. The reviewing person (Team Leader or Clinical Coordinator) should sign in the folder to indicate the case was reviewed. This review can occur either via a case staffing or individual case supervision and should occur within the first five visits. Further and ongoing case review should be as determined by the Team Leader.

b. Emergent Case Management

(1) For response to cases of potential violence and/or suicide by clients, a comprehensive crisis intervention guideline is required at all Vet Centers. This should be prepared under the supervision and with the approval of the Regional Manager or designee.

NOTE: RCS (Readjustment Counseling Service) regional managers are directly responsible for all clinical and administrative operations for each Vet Center within the RCS regions.

(2) A mortality and morbidity review should be completed in a timely manner, in cases of homicides by and/or suicides of active cases.

M-12, Part II
Chapter 5 April 21, 1992

4.06 CASE CONFERENCES AND SUPERVISION

a. Case Conferences. Depending on the needs of the particular Vet Center, clinical consultations provided by a VA medical center/VA outpatient clinic staff take place on a regularly scheduled basis at least 1 hour per week or 2 hours every 2 weeks unless arranged through some alternative manner. Clinical consultants requiring credentialing and privileging will be credentialed and privileged consistent with the requirements of the VA support facility.

b. Supervision. Individual clinical supervision is provided regularly by the appropriate Team Leader or Clinical Coordinator. The Vet Center clinical consultant(s) provides consultation to all team service providers including the Team Leader and Clinical Coordinator.

4.07 CLINICAL COORDINATION AND PROFESSIONAL COLLABORATION BETWEEN VET CENTERS AND VA MEDICAL CENTERS

a. Vet Center staff should achieve maximum feasible joint participation with appropriate medical center and outpatient clinic staff in:

(1) Case conferences,

(2) Clinical consultations,

(3) Presentations to veterans organizations and others, and

(4) Shared opportunities for continued professional growth.

b. Vet Center staff should participate in professional continuing education opportunities sponsored by the supporting VA facility both as faculty and as trainees, as appropriate. Conversely, Vet Centers should arrange participation by interested VA medical center staff both as faculty and as trainees, as appropriate, in Vet Center sponsored training.

c. Such collaboration provides the required opportunities for skill development and enhances continuity of care for veterans served.